WORKERS' DISABILITY COMPENSATION
GROUP SELF-INSURER APPLICATION

Michigan Department of Consumer & Industry Services
Bureau of Workers' Compensation
Self-Insured Programs
7150 Harris Drive (48913)
PO Box 30016
Lansing, Michigan 48909

New _____

Renewal _____

Authority: Workers' Disability Compensation Act of 1969, as amended Completion: Mandatory Penalty: Denial/Termination of Self-Insured Status	The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, height, weight, or political belief.

1. APPLICANT:

Applicant Group:	
Address:	
City, State, Zip Code:	FEIN No.

2. TRUSTEES:

Name:	Business Address:

3. ADMINISTRATOR:

Name:	Telephone:
Address:	Fax Number:

4. CLAIMS PROGRAM:

Service Company:	Telephone:
Address:	Fax Number:

5. SAFETY PROGRAM:

Name:	Telephone:
Address:	Fax Number:

6. ON NEW APPLICATIONS: Attach an exhibit detailing the following by applicable code classification for the proposed year: code classification, payroll, rate per $100, manual premium, modified premium and discount, if applicable.

7. ON RENEWAL APPLICATIONS: Attach an exhibit detailing the following by applicable code classification for the renewal year: code classification, payroll, rate per $100, manual premium, modified premium and discount, if applicable.

Number of Employer Members: (Attach Membership List)	Group Experience Modifier:
Excess Carrier:	Standard Premium:
Policy Number:	Discounts:
Total Estimated Premium:	Collectable Premium:

RENEWAL APPLICANTS MUST ATTACH A CURRENT LOSS SUMMARY FOR ALL GROUP YEARS, AND A COPY OF THE CURRENT FINANCIAL REPORT.

8. EXCESS INSURANCE AND BOND INFORMATION:

Specific Excess Policy Limit:	**Aggregate Excess** Policy Limit:
Retention:	Term:
Term:	Loss Fund % of Collectable Premium:
Fidelity Policy: Amount: Bond Number: Carrier:	Estimated Loss Fund:
Surety Bond: Amount: Bond Number: Carrier:	Minimum Loss Fund:

ALL EXCESS INSURANCE TERMS MUST BE CONFIRMED AND PROVIDED WITH THE APPLICATION, INCLUDING A COPY OF THE GROUP'S FIDELITY POLICY WITH PROOF THAT THE FIDELITY POLICY IS CURRENT. THIS APPLICATION MUST BE RECEIVED BY THE BUREAU 30 DAYS PRIOR TO ITS EFFECTIVE DATE.

9. PROJECTED ADMINISTRATIVE EXPENSE:

Estimated Collected Premium:_____

Excess Insurance:	In dollars	As % of premium
Service Company Fee:		
Bonds and Other Insurance:		
General Administrative Expenses:		

ATTACH A COPY OF THE SERVICE COMPANY AND ADMINISTRATOR CONTRACTS.

In consideration of the privilege of being a group self-insurer, we hereby agree:

a. That we will discharge our liability for compensation to injured employees or their dependents in accordance with the requirements of the Michigan Workers' Disability Compensation Act of 1969, as amended.

b. That we will follow the administrative rules of the bureau and any additional conditions imposed by the bureau as part of our approval.

c. That we will promptly furnish all reports to the Bureau of Workers' Compensation which it may lawfully require under the Michigan Workers' Disability Compensation Act of 1969, as amended.

d. That we will notify the Bureau of Workers' Compensation promptly of any unfavorable turn in our financial condition which might reasonably reduce our ability to carry our own risk under the Michigan Workers' Disability Compensation Act of 1969, as amended.

We affirm all information submitted as being true.

GROUP NAME: _____

_____

BY: _____
Type Name of Person Signing

TITLE: _____
Title of Person Signing

SIGNATURE: _____

NOTARY SIGNATURE: _____

COUNTY OF: _____

MY COMMISSION EXPIRES: _____

DATE: _____

AFFIX STAMP: